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SUBSTANTIVE ISSUES ARISING IN THE IMPLEMENTATION OF THE INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS

General Comment No. 14 (2000)

The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights)

1. Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity. The realization of the right to health may be pursued through numerous, complementary approaches, such as the formulation of health policies, or the implementation of health programmes developed by the World Health Organization (WHO), or the adoption of specific legal instruments. Moreover, the right to health includes certain components which are legally enforceable.[1]

2. The human right to health is recognized in numerous international instruments. Article 25.1 of the Universal Declaration of Human Rights affirms: "Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services". The International Covenant on Economic, Social and Cultural Rights provides the most comprehensive article on the right to

health in international human rights law. In accordance with article 12.1 of the Covenant, States parties recognize "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health", while article 12.2 enumerates, by way of illustration, a number of "steps to be taken by the States parties ... to achieve the full realization of this right". Additionally, the right to health is recognized, *inter alia*, in article 5 (e) (iv) of the International Convention on the Elimination of All Forms of Racial Discrimination of 1965, in articles 11.1 (f) and 12 of the Convention on the Elimination of All Forms of Discrimination against Women of 1979 and in article 24 of the Convention on the Rights of the Child of 1989. Several regional human rights instruments also recognize the right to health, such as the European Social Charter of 1961 as revised (art. 11), the African Charter on Human and Peoples' Rights of 1981 (art. 16) and the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights of 1988 (art. 10). Similarly, the right to health has been proclaimed by the Commission on Human Rights,[2] as well as in the Vienna Declaration and Programme of Action of 1993 and other international instruments.[3]

3. The right to health is closely related to and dependent upon the realization of other human rights, as contained in the International Bill of Rights, including the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement. These and other rights and freedoms address integral components of the right to health.

4. In drafting article 12 of the Covenant, the Third Committee of the United Nations General Assembly did not adopt the definition of health contained in the preamble to the Constitution of WHO, which conceptualizes health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". However, the reference in article 12.1 of the Covenant to "the highest attainable standard of physical and mental health" is not confined to the right to health care. On the contrary, the drafting history and the express wording of article 12.2 acknowledge that the right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment.

5. The Committee is aware that, for millions of people throughout the world, the full enjoyment of the right to health still remains a distant goal. Moreover, in many cases, especially for those living in poverty, this goal is becoming increasingly remote. The Committee recognizes the formidable structural and other obstacles resulting from international and other factors beyond the control of States that impede the full realization of article 12 in many States parties.

6. With a view to assisting States parties' implementation of the Covenant and the fulfilment of their reporting obligations, this General Comment focuses on the normative content of article 12 (Part I), States parties' obligations (Part II), violations (Part III) and implementation

at the national level (Part IV), while the obligations of actors other than States parties are addressed in Part V. The General Comment is based on the Committee's experience in examining States parties' reports over many years.

I. NORMATIVE CONTENT OF ARTICLE 12

7. Article 12.1 provides a definition of the right to health, while article 12.2 enumerates illustrative, non-exhaustive examples of States parties' obligations.

8. The right to health is not to be understood as a right to be *healthy*. The right to health contains both freedoms and entitlements. The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.

9. The notion of "the highest attainable standard of health" in article 12.1 takes into account both the individual's biological and socio-economic preconditions and a State's available resources. There are a number of aspects which cannot be addressed solely within the relationship between States and individuals; in particular, good health cannot be ensured by a State, nor can States provide protection against every possible cause of human ill health. Thus, genetic factors, individual susceptibility to ill health and the adoption of unhealthy or risky lifestyles may play an important role with respect to an individual's health. Consequently, the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health.

10. Since the adoption of the two International Covenants in 1966 the world health situation has changed dramatically and the notion of health has undergone substantial changes and has also widened in scope. More determinants of health are being taken into consideration, such as resource distribution and gender differences. A wider definition of health also takes into account such socially-related concerns as violence and armed conflict.[4] Moreover, formerly unknown diseases, such as Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome (HIV/AIDS), and others that have become more widespread, such as cancer, as well as the rapid growth of the world population, have created new obstacles for the realization of the right to health which need to be taken into account when interpreting article 12.

11. The Committee interprets the right to health, as defined in article 12.1, as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health. A further important aspect is the participation of the population in all health-related decision-making at the community, national and international levels.

12. The right to health in all its forms and at all levels contains the following interrelated and essential elements, the precise application of which will depend on the conditions prevailing in a particular State party:

(a) *Availability*. Functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party. The precise nature of the facilities, goods and services will vary depending on numerous factors, including the State party's developmental level. They will include, however, the underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by the WHO Action Programme on Essential Drugs.[5]

(b) *Accessibility*. Health facilities, goods and services[6] have to be accessible to everyone without discrimination, within the jurisdiction of the State party. Accessibility has four overlapping dimensions:

(i) Non-discrimination: health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds.[7]

(ii) Physical accessibility: health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS. Accessibility also implies that medical services and underlying determinants of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas. Accessibility further includes adequate access to buildings for persons with disabilities.

(iii) Economic accessibility (affordability): health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.

(iv) Information accessibility: accessibility includes the right to seek, receive and impart information and ideas[8] concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality.

(c) *Acceptability*. All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.

(d) *Quality*. As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, *inter alia*, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.

13. The non-exhaustive catalogue of examples in article 12.2 provides guidance in defining the action to be taken by States. It gives specific generic examples of measures arising from the broad definition of the right to health contained in article 12.1, thereby illustrating the content of that right, as exemplified in the following paragraphs.[9]

Article 12.2 (a). The right to maternal, child and reproductive health

14. "The provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child" (art. 12.2 (a))[10] may be understood as requiring measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre- and post-natal care,[11] emergency obstetric services and access to information, as well as to resources necessary to act on that information.[12]

Article 12.2 (b). The right to healthy natural and workplace environments

15. "The improvement of all aspects of environmental and industrial hygiene" (art. 12.2 (b)) comprises, *inter alia*, preventive measures in respect of occupational accidents and diseases; the requirement to ensure an adequate supply of safe and potable water and basic sanitation; the prevention and reduction of the population's exposure to harmful substances such as radiation and harmful chemicals or other detrimental environmental conditions that directly or indirectly impact upon human health.[13] Furthermore, industrial hygiene refers to the minimization, so far as is reasonably practicable, of the causes of health hazards inherent in the working environment.[14] Article 12.2 (b) also embraces adequate housing and safe and hygienic working conditions, an adequate supply of food and proper nutrition, and discourages the abuse of alcohol, and the use of tobacco, drugs and other harmful substances.

Article 12.2 (c). The right to prevention, treatment and control of diseases

16. "The prevention, treatment and control of epidemic, endemic, occupational and other diseases" (art. 12.2 (c)) requires the establishment of prevention and education programmes for behaviour-related health concerns such as sexually transmitted diseases, in particular HIV/AIDS, and those adversely affecting sexual and reproductive health, and the promotion of social determinants of good health, such as environmental safety, education, economic development and gender equity. The right to treatment includes the creation of a system of urgent medical care in cases of accidents, epidemics and similar health hazards, and the provision of disaster relief and humanitarian assistance in emergency situations. The control of diseases refers to States' individual and joint efforts to, *inter alia*, make available relevant technologies, using and

improving epidemiological surveillance and data collection on a disaggregated basis, the implementation or enhancement of immunization programmes and other strategies of infectious disease control.

Article 12.2 (d). The right to health facilities, goods and services[15]

17. "The creation of conditions which would assure to all medical service and medical attention in the event of sickness" (art. 12.2 (d)), both physical and mental, includes the provision of equal and timely access to basic preventive, curative, rehabilitative health services and health education; regular screening programmes; appropriate treatment of prevalent diseases, illnesses, injuries and disabilities, preferably at community level; the provision of essential drugs; and appropriate mental health treatment and care. A further important aspect is the improvement and furtherance of participation of the population in the provision of preventive and curative health services, such as the organization of the health sector, the insurance system and, in particular, participation in political decisions relating to the right to health taken at both the community and national levels.

Article 12. Special topics of broad application

Non-discrimination and equal treatment

18. By virtue of article 2.2 and article 3, the Covenant proscribes any discrimination in access to health care and underlying determinants of health, as well as to means and entitlements for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health. The Committee stresses that many measures, such as most strategies and programmes designed to eliminate health-related discrimination, can be pursued with minimum resource implications through the adoption, modification or abrogation of legislation or the dissemination of information. The Committee recalls General Comment No. 3, paragraph 12, which states that even in times of severe resource constraints, the vulnerable members of society must be protected by the adoption of relatively low-cost targeted programmes.

19. With respect to the right to health, equality of access to health care and health services has to be emphasized. States have a special obligation to provide those who do not have sufficient means with the necessary health insurance and health-care facilities, and to prevent any discrimination on internationally prohibited grounds in the provision of health care and health services, especially with respect to the core obligations of the right to health.[16] Inappropriate health resource allocation can lead to discrimination that may not be overt. For example, investments should not disproportionately favour expensive curative health services which are often accessible only to a small, privileged fraction of the population, rather than primary and preventive health care benefiting a far larger part of the population.

Gender perspective

20. The Committee recommends that States integrate a gender perspective in their health-related policies, planning, programmes and research in order to promote better health for both women and men. A gender-based approach recognizes that biological and socio-cultural factors play a significant role in influencing the health of men and women. The disaggregation of health and socio-economic data according to sex is essential for identifying and remedying inequalities in health.

Women and the right to health

21. To eliminate discrimination against women, there is a need to develop and implement a comprehensive national strategy for promoting women's right to health throughout their life span. Such a strategy should include interventions aimed at the prevention and treatment of diseases affecting women, as well as policies to provide access to a full range of high quality and affordable health care, including sexual and reproductive services. A major goal should be reducing women's health risks, particularly lowering rates of maternal mortality and protecting women from domestic violence. The realization of women's right to health requires the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health. It is also important to undertake preventive, promotive and remedial action to shield women from the impact of harmful traditional cultural practices and norms that deny them their full reproductive rights.

Children and adolescents

22. Article 12.2 (a) outlines the need to take measures to reduce infant mortality and promote the healthy development of infants and children. Subsequent international human rights instruments recognize that children and adolescents have the right to the enjoyment of the highest standard of health and access to facilities for the treatment of illness.[17] The Convention on the Rights of the Child directs States to ensure access to essential health services for the child and his or her family, including pre- and post-natal care for mothers. The Convention links these goals with ensuring access to child-friendly information about preventive and health-promoting behaviour and support to families and communities in implementing these practices. Implementation of the principle of non-discrimination requires that girls, as well as boys, have equal access to adequate nutrition, safe environments, and physical as well as mental health services. There is a need to adopt effective and appropriate measures to abolish harmful traditional practices affecting the health of children, particularly girls, including early marriage, female genital mutilation, preferential feeding and care of male children.[18] Children with disabilities should be given the opportunity to enjoy a fulfilling and decent life and to participate within their community.

23. States parties should provide a safe and supportive environment for adolescents, that ensures the opportunity to participate in decisions affecting their health, to build life-skills, to acquire appropriate information, to receive counselling and to negotiate the health-behaviour choices they make. The realization of the right to health of adolescents is dependent on the development of youth-friendly health care, which respects confidentiality and privacy and includes appropriate sexual and reproductive health services.

24. In all policies and programmes aimed at guaranteeing the right to health of children and adolescents their best interests shall be a primary consideration.

Older persons

25. With regard to the realization of the right to health of older persons, the Committee, in accordance with paragraphs 34 and 35 of General Comment No. 6 (1995), reaffirms the importance of an integrated approach, combining elements of preventive, curative and rehabilitative health treatment. Such measures should be based on periodical check-ups for both sexes; physical as well as psychological rehabilitative measures aimed at maintaining the functionality and autonomy of older persons; and attention and care for chronically and terminally ill persons, sparing them avoidable pain and enabling them to die with dignity.

Persons with disabilities

26. The Committee reaffirms paragraph 34 of its General Comment No. 5, which addresses the issue of persons with disabilities in the context of the right to physical and mental health. Moreover, the Committee stresses the need to ensure that not only the public health sector but also private providers of health services and facilities comply with the principle of non-discrimination in relation to persons with disabilities.

Indigenous peoples

27. In the light of emerging international law and practice and the recent measures taken by States in relation to indigenous peoples,[19] the Committee deems it useful to identify elements that would help to define indigenous peoples' right to health in order better to enable States with indigenous peoples to implement the provisions contained in article 12 of the Covenant. The Committee considers that indigenous peoples have the right to specific measures to improve their access to health services and care. These health services should be culturally appropriate, taking into account traditional preventive care, healing practices and medicines. States should provide resources for indigenous peoples to design, deliver and control such services so that they may enjoy the highest attainable standard of physical and mental health. The vital medicinal plants, animals and minerals necessary to the full enjoyment of health of indigenous peoples should also be protected. The Committee notes that, in indigenous communities, the health of the individual is often linked to the health of the society as a whole and has a collective dimension. In this respect, the Committee considers that development-related activities that lead to the displacement of indigenous peoples against their will from their traditional territories and environment, denying them their sources of nutrition and breaking their symbiotic relationship with their lands, has a deleterious effect on their health.

Limitations

28. Issues of public health are sometimes used by States as grounds for limiting the exercise of other fundamental rights. The Committee wishes to emphasize that the Covenant's limitation clause, article 4, is primarily intended to protect the rights of individuals rather than to permit the imposition of limitations by States. Consequently a State party which, for example, restricts the movement of, or incarcerates, persons with transmissible diseases such as HIV/AIDS, refuses to

allow doctors to treat persons believed to be opposed to a government, or fails to provide immunization against the community's major infectious diseases, on grounds such as national security or the preservation of public order, has the burden of justifying such serious measures in relation to each of the elements identified in article 4. Such restrictions must be in accordance with the law, including international human rights standards, compatible with the nature of the rights protected by the Covenant, in the interest of legitimate aims pursued, and strictly necessary for the promotion of the general welfare in a democratic society.

29. In line with article 5.1, such limitations must be proportional, i.e. the least restrictive alternative must be adopted where several types of limitations are available. Even where such limitations on grounds of protecting public health are basically permitted, they should be of limited duration and subject to review.

II. STATES PARTIES' OBLIGATIONS

General legal obligations

30. While the Covenant provides for progressive realization and acknowledges the constraints due to the limits of available resources, it also imposes on States parties various obligations which are of immediate effect. States parties have immediate obligations in relation to the right to health, such as the guarantee that the right will be exercised without discrimination of any kind (art. 2.2) and the obligation to take steps (art. 2.1) towards the full realization of article 12. Such steps must be deliberate, concrete and targeted towards the full realization of the right to health.[20]

31. The progressive realization of the right to health over a period of time should not be interpreted as depriving States parties' obligations of all meaningful content. Rather, progressive realization means that States parties have a specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization of article 12.[21]

32. As with all other rights in the Covenant, there is a strong presumption that retrogressive measures taken in relation to the right to health are not permissible. If any deliberately retrogressive measures are taken, the State party has the burden of proving that they have been introduced after the most careful consideration of all alternatives and that they are duly justified by reference to the totality of the rights provided for in the Covenant in the context of the full use of the State party's maximum available resources.[22]

33. The right to health, like all human rights, imposes three types or levels of obligations on States parties: the obligations to *respect*, *protect* and *fulfil*. In turn, the obligation to fulfil contains obligations to facilitate, provide and promote.[23] The obligation to *respect* requires States to refrain from interfering directly or indirectly with the enjoyment of the right to health. The obligation to *protect* requires States to take measures that prevent third parties from interfering with article 12 guarantees. Finally, the obligation to *fulfil* requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health.

Specific legal obligations

34. In particular, States are under the obligation to *respect* the right to health by, *inter alia*, refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventive, curative and palliative health services; abstaining from enforcing discriminatory practices as a State policy; and abstaining from imposing discriminatory practices relating to women's health status and needs. Furthermore, obligations to respect include a State's obligation to refrain from prohibiting or impeding traditional preventive care, healing practices and medicines, from marketing unsafe drugs and from applying coercive medical treatments, unless on an exceptional basis for the treatment of mental illness or the prevention and control of communicable diseases. Such exceptional cases should be subject to specific and restrictive conditions, respecting best practices and applicable international standards, including the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care.[24] In addition, States should refrain from limiting access to contraceptives and other means of maintaining sexual and reproductive health, from censoring, withholding or intentionally misrepresenting health-related information, including sexual education and information, as well as from preventing people's participation in health-related matters. States should also refrain from unlawfully polluting air, water and soil, e.g. through industrial waste from State-owned facilities, from using or testing nuclear, biological or chemical weapons if such testing results in the release of substances harmful to human health, and from limiting access to health services as a punitive measure, e.g. during armed conflicts in violation of international humanitarian law.

35. Obligations to *protect* include, *inter alia*, the duties of States to adopt legislation or to take other measures ensuring equal access to health care and health-related services provided by third parties; to ensure that privatization of the health sector does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services; to control the marketing of medical equipment and medicines by third parties; and to ensure that medical practitioners and other health professionals meet appropriate standards of education, skill and ethical codes of conduct. States are also obliged to ensure that harmful social or traditional practices do not interfere with access to pre- and post-natal care and family-planning; to prevent third parties from coercing women to undergo traditional practices, e.g. female genital mutilation; and to take measures to protect all vulnerable or marginalized groups of society, in particular women, children, adolescents and older persons, in the light of gender-based expressions of violence. States should also ensure that third parties do not limit people's access to health-related information and services.

36. The obligation to *fulfil* requires States parties, *inter alia*, to give sufficient recognition to the right to health in the national political and legal systems, preferably by way of legislative implementation, and to adopt a national health policy with a detailed plan for realizing the right to health. States must ensure provision of health care, including immunization programmes against the major infectious diseases, and ensure equal access for all to the underlying determinants of health, such as nutritiously safe food and potable drinking water, basic sanitation and adequate housing and living conditions. Public health infrastructures should provide for sexual and reproductive health services, including safe motherhood, particularly in rural areas. States have to ensure the appropriate training of doctors and other medical personnel, the provision of a sufficient number of hospitals, clinics and other health-related facilities, and the

promotion and support of the establishment of institutions providing counselling and mental health services, with due regard to equitable distribution throughout the country. Further obligations include the provision of a public, private or mixed health insurance system which is affordable for all, the promotion of medical research and health education, as well as information campaigns, in particular with respect to HIV/AIDS, sexual and reproductive health, traditional practices, domestic violence, the abuse of alcohol and the use of cigarettes, drugs and other harmful substances. States are also required to adopt measures against environmental and occupational health hazards and against any other threat as demonstrated by epidemiological data. For this purpose they should formulate and implement national policies aimed at reducing and eliminating pollution of air, water and soil, including pollution by heavy metals such as lead from gasoline. Furthermore, States parties are required to formulate, implement and periodically review a coherent national policy to minimize the risk of occupational accidents and diseases, as well as to provide a coherent national policy on occupational safety and health services.[25]

37. The obligation to *fulfil (facilitate)* requires States *inter alia* to take positive measures that enable and assist individuals and communities to enjoy the right to health. States parties are also obliged to *fulfil (provide)* a specific right contained in the Covenant when individuals or a group are unable, for reasons beyond their control, to realize that right themselves by the means at their disposal. The obligation to *fulfil (promote)* the right to health requires States to undertake actions that create, maintain and restore the health of the population. Such obligations include: (i) fostering recognition of factors favouring positive health results, e.g. research and provision of information; (ii) ensuring that health services are culturally appropriate and that health care staff are trained to recognize and respond to the specific needs of vulnerable or marginalized groups; (iii) ensuring that the State meets its obligations in the dissemination of appropriate information relating to healthy lifestyles and nutrition, harmful traditional practices and the availability of services; (iv) supporting people in making informed choices about their health.

International obligations

38. In its General Comment No. 3, the Committee drew attention to the obligation of all States parties to take steps, individually and through international assistance and cooperation, especially economic and technical, towards the full realization of the rights recognized in the Covenant, such as the right to health. In the spirit of article 56 of the Charter of the United Nations, the specific provisions of the Covenant (articles 12, 2.1, 22 and 23) and the Alma-Ata Declaration on primary health care, States parties should recognize the essential role of international cooperation and comply with their commitment to take joint and separate action to achieve the full realization of the right to health. In this regard, States parties are referred to the Alma-Ata Declaration which proclaims that the existing gross inequality in the health status of the people, particularly between developed and developing countries, as well as within countries, is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.[26]

39. To comply with their international obligations in relation to article 12, States parties have to respect the enjoyment of the right to health in other countries, and to prevent third parties from violating the right in other countries, if they are able to influence these third parties by way of legal or political means, in accordance with the Charter of the United Nations and applicable international law. Depending on the availability of resources, States should facilitate access to

essential health facilities, goods and services in other countries, wherever possible and provide the necessary aid when required.[27] States parties should ensure that the right to health is given due attention in international agreements and, to that end, should consider the development of further legal instruments. In relation to the conclusion of other international agreements, States parties should take steps to ensure that these instruments do not adversely impact upon the right to health. Similarly, States parties have an obligation to ensure that their actions as members of international organizations take due account of the right to health. Accordingly, States parties which are members of international financial institutions, notably the International Monetary Fund, the World Bank, and regional development banks, should pay greater attention to the protection of the right to health in influencing the lending policies, credit agreements and international measures of these institutions.

40. States parties have a joint and individual responsibility, in accordance with the Charter of the United Nations and relevant resolutions of the United Nations General Assembly and of the World Health Assembly, to cooperate in providing disaster relief and humanitarian assistance in times of emergency, including assistance to refugees and internally displaced persons. Each State should contribute to this task to the maximum of its capacities. Priority in the provision of international medical aid, distribution and management of resources, such as safe and potable water, food and medical supplies, and financial aid should be given to the most vulnerable or marginalized groups of the population. Moreover, given that some diseases are easily transmissible beyond the frontiers of a State, the international community has a collective responsibility to address this problem. The economically developed States parties have a special responsibility and interest to assist the poorer developing States in this regard.

41. States parties should refrain at all times from imposing embargoes or similar measures restricting the supply of another State with adequate medicines and medical equipment. Restrictions on such goods should never be used as an instrument of political and economic pressure. In this regard, the Committee recalls its position, stated in General Comment No. 8, on the relationship between economic sanctions and respect for economic, social and cultural rights.

42. While only States are parties to the Covenant and thus ultimately accountable for compliance with it, all members of society - individuals, including health professionals, families, local communities, intergovernmental and non-governmental organizations, civil society organizations, as well as the private business sector - have responsibilities regarding the realization of the right to health. State parties should therefore provide an environment which facilitates the discharge of these responsibilities.

Core obligations

43. In General Comment No. 3, the Committee confirms that States parties have a core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights enunciated in the Covenant, including essential primary health care. Read in conjunction with more contemporary instruments, such as the Programme of Action of the International Conference on Population and Development,[28] the Alma-Ata Declaration provides compelling guidance on the core obligations arising from article 12. Accordingly, in the Committee's view, these core obligations include at least the following obligations:

(a) To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;

(b) To ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone;

(c) To ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;

(d) To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;

(e) To ensure equitable distribution of all health facilities, goods and services;

(f) To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include methods, such as right to health indicators and benchmarks, by which progress can be closely monitored; the process by which the strategy and plan of action are devised, as well as their content, shall give particular attention to all vulnerable or marginalized groups.

44. The Committee also confirms that the following are obligations of comparable priority:

(a) To ensure reproductive, maternal (pre-natal as well as post-natal) and child health care;

(b) To provide immunization against the major infectious diseases occurring in the community;

(c) To take measures to prevent, treat and control epidemic and endemic diseases;

(d) To provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them;

(e) To provide appropriate training for health personnel, including education on health and human rights.

45. For the avoidance of any doubt, the Committee wishes to emphasize that it is particularly incumbent on States parties and other actors in a position to assist, to provide "international assistance and cooperation, especially economic and technical"[29] which enable developing countries to fulfil their core and other obligations indicated in paragraphs 43 and 44 above.

III. VIOLATIONS

46. When the normative content of article 12 (Part I) is applied to the obligations of States parties (Part II), a dynamic process is set in motion which facilitates identification of violations of the right to health. The following paragraphs provide illustrations of violations of article 12.

47. In determining which actions or omissions amount to a violation of the right to health, it is important to distinguish the inability from the unwillingness of a State party to comply with its obligations under article 12. This follows from article 12.1, which speaks of the highest attainable standard of health, as well as from article 2.1 of the Covenant, which obliges each State party to take the necessary steps to the maximum of its available resources. A State which is unwilling to use the maximum of its available resources for the realization of the right to health is in violation of its obligations under article 12. If resource constraints render it impossible for a State to comply fully with its Covenant obligations, it has the burden of justifying that every effort has nevertheless been made to use all available resources at its disposal in order to satisfy, as a matter of priority, the obligations outlined above. It should be stressed, however, that a State party cannot, under any circumstances whatsoever, justify its non-compliance with the core obligations set out in paragraph 43 above, which are non-derogable.

48. Violations of the right to health can occur through the direct action of States or other entities insufficiently regulated by States. The adoption of any retrogressive measures incompatible with the core obligations under the right to health, outlined in paragraph 43 above, constitutes a violation of the right to health. Violations through *acts of commission* include the formal repeal or suspension of legislation necessary for the continued enjoyment of the right to health or the adoption of legislation or policies which are manifestly incompatible with pre-existing domestic or international legal obligations in relation to the right to health.

49. Violations of the right to health can also occur through the omission or failure of States to take necessary measures arising from legal obligations. Violations through *acts of omission* include the failure to take appropriate steps towards the full realization of everyone's right to the enjoyment of the highest attainable standard of physical and mental health, the failure to have a national policy on occupational safety and health as well as occupational health services, and the failure to enforce relevant laws.

Violations of the obligation to respect

50. Violations of the obligation to respect are those State actions, policies or laws that contravene the standards set out in article 12 of the Covenant and are likely to result in bodily harm, unnecessary morbidity and preventable mortality. Examples include the denial of access to health facilities, goods and services to particular individuals or groups as a result of de jure or de facto discrimination; the deliberate withholding or misrepresentation of information vital to health protection or treatment; the suspension of legislation or the adoption of laws or policies that interfere with the enjoyment of any of the components of the right to health; and the failure of the State to take into account its legal obligations regarding the right to health when entering into bilateral or multilateral agreements with other States, international organizations and other entities, such as multinational corporations.

Violations of the obligation to protect

51. Violations of the obligation to protect follow from the failure of a State to take all necessary measures to safeguard persons within their jurisdiction from infringements of the right to health by third parties. This category includes such omissions as the failure to regulate the activities of individuals, groups or corporations so as to prevent them from violating the right to health of others; the failure to protect consumers and workers from practices detrimental to health, e.g. by employers and manufacturers of medicines or food; the failure to discourage production, marketing and consumption of tobacco, narcotics and other harmful substances; the failure to protect women against violence or to prosecute perpetrators; the failure to discourage the continued observance of harmful traditional medical or cultural practices; and the failure to enact or enforce laws to prevent the pollution of water, air and soil by extractive and manufacturing industries.

Violations of the obligation to fulfil

52. Violations of the obligation to fulfil occur through the failure of States parties to take all necessary steps to ensure the realization of the right to health. Examples include the failure to adopt or implement a national health policy designed to ensure the right to health for everyone; insufficient expenditure or misallocation of public resources which results in the non-enjoyment of the right to health by individuals or groups, particularly the vulnerable or marginalized; the failure to monitor the realization of the right to health at the national level, for example by identifying right to health indicators and benchmarks; the failure to take measures to reduce the inequitable distribution of health facilities, goods and services; the failure to adopt a gender-sensitive approach to health; and the failure to reduce infant and maternal mortality rates.

IV. IMPLEMENTATION AT THE NATIONAL LEVEL

Framework legislation

53. The most appropriate feasible measures to implement the right to health will vary significantly from one State to another. Every State has a margin of discretion in assessing which measures are most suitable to meet its specific circumstances. The Covenant, however, clearly imposes a duty on each State to take whatever steps are necessary to ensure that everyone has access to health facilities, goods and services so that they can enjoy, as soon as possible, the highest attainable standard of physical and mental health. This requires the adoption of a national strategy to ensure to all the enjoyment of the right to health, based on human rights principles which define the objectives of that strategy, and the formulation of policies and corresponding right to health indicators and benchmarks. The national health strategy should also identify the resources available to attain defined objectives, as well as the most cost-effective way of using those resources.

54. The formulation and implementation of national health strategies and plans of action should respect, *inter alia*, the principles of non-discrimination and people's participation. In particular, the right of individuals and groups to participate in decision-making processes, which may affect their development, must be an integral component of any policy, programme or strategy developed to discharge governmental obligations under article 12. Promoting health

must involve effective community action in setting priorities, making decisions, planning, implementing and evaluating strategies to achieve better health. Effective provision of health services can only be assured if people's participation is secured by States.

55. The national health strategy and plan of action should also be based on the principles of accountability, transparency and independence of the judiciary, since good governance is essential to the effective implementation of all human rights, including the realization of the right to health. In order to create a favourable climate for the realization of the right, States parties should take appropriate steps to ensure that the private business sector and civil society are aware of, and consider the importance of, the right to health in pursuing their activities.

56. States should consider adopting a framework law to operationalize their right to health national strategy. The framework law should establish national mechanisms for monitoring the implementation of national health strategies and plans of action. It should include provisions on the targets to be achieved and the time-frame for their achievement; the means by which right to health benchmarks could be achieved; the intended collaboration with civil society, including health experts, the private sector and international organizations; institutional responsibility for the implementation of the right to health national strategy and plan of action; and possible recourse procedures. In monitoring progress towards the realization of the right to health, States parties should identify the factors and difficulties affecting implementation of their obligations.

Right to health indicators and benchmarks

57. National health strategies should identify appropriate right to health indicators and benchmarks. The indicators should be designed to monitor, at the national and international levels, the State party's obligations under article 12. States may obtain guidance on appropriate right to health indicators, which should address different aspects of the right to health, from the ongoing work of WHO and the United Nations Children's Fund (UNICEF) in this field. Right to health indicators require disaggregation on the prohibited grounds of discrimination.

58. Having identified appropriate right to health indicators, States parties are invited to set appropriate national benchmarks in relation to each indicator. During the periodic reporting procedure the Committee will engage in a process of scoping with the State party. Scoping involves the joint consideration by the State party and the Committee of the indicators and national benchmarks which will then provide the targets to be achieved during the next reporting period. In the following five years, the State party will use these national benchmarks to help monitor its implementation of article 12. Thereafter, in the subsequent reporting process, the State party and the Committee will consider whether or not the benchmarks have been achieved, and the reasons for any difficulties that may have been encountered.

Remedies and accountability

59. Any person or group victim of a violation of the right to health should have access to effective judicial or other appropriate remedies at both national and international levels.[30] All victims of such violations should be entitled to adequate reparation, which may take the form of

restitution, compensation, satisfaction or guarantees of non-repetition. National ombudsmen, human rights commissions, consumer forums, patients' rights associations or similar institutions should address violations of the right to health.

60. The incorporation in the domestic legal order of international instruments recognizing the right to health can significantly enhance the scope and effectiveness of remedial measures and should be encouraged in all cases.[31] Incorporation enables courts to adjudicate violations of the right to health, or at least its core obligations, by direct reference to the Covenant.

61. Judges and members of the legal profession should be encouraged by States parties to pay greater attention to violations of the right to health in the exercise of their functions.

62. States parties should respect, protect, facilitate and promote the work of human rights advocates and other members of civil society with a view to assisting vulnerable or marginalized groups in the realization of their right to health.

V. OBLIGATIONS OF ACTORS OTHER THAN STATES PARTIES

63. The role of the United Nations agencies and programmes, and in particular the key function assigned to WHO in realizing the right to health at the international, regional and country levels, is of particular importance, as is the function of UNICEF in relation to the right to health of children. When formulating and implementing their right to health national strategies, States parties should avail themselves of technical assistance and cooperation of WHO. Further, when preparing their reports, States parties should utilize the extensive information and advisory services of WHO with regard to data collection, disaggregation, and the development of right to health indicators and benchmarks.

64. Moreover, coordinated efforts for the realization of the right to health should be maintained to enhance the interaction among all the actors concerned, including the various components of civil society. In conformity with articles 22 and 23 of the Covenant, WHO, The International Labour Organization, the United Nations Development Programme, UNICEF, the United Nations Population Fund, the World Bank, regional development banks, the International Monetary Fund, the World Trade Organization and other relevant bodies within the United Nations system, should cooperate effectively with States parties, building on their respective expertise, in relation to the implementation of the right to health at the national level, with due respect to their individual mandates. In particular, the international financial institutions, notably the World Bank and the International Monetary Fund, should pay greater attention to the protection of the right to health in their lending policies, credit agreements and structural adjustment programmes. When examining the reports of States parties and their ability to meet the obligations under article 12, the Committee will consider the effects of the assistance provided by all other actors. The adoption of a human rights-based approach by United Nations specialized agencies, programmes and bodies will greatly facilitate implementation of the right to health. In the course of its examination of States parties' reports, the Committee will also consider the role of health professional associations and other non-governmental organizations in relation to the States' obligations under article 12.

65. The role of WHO, the Office of the United Nations High Commissioner for Refugees, the International Committee of the Red Cross/Red Crescent and UNICEF, as well as non governmental organizations and national medical associations, is of particular importance in relation to disaster relief and humanitarian assistance in times of emergencies, including assistance to refugees and internally displaced persons. Priority in the provision of international medical aid, distribution and management of resources, such as safe and potable water, food and medical supplies, and financial aid should be given to the most vulnerable or marginalized groups of the population.

Adopted on 11 May 2000.

Notes

[1] For example, the principle of non-discrimination in relation to health facilities, goods and services is legally enforceable in numerous national jurisdictions.

[2] In its resolution 1989/11.

[3] The Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care adopted by the United Nations General Assembly in 1991 (resolution 46/119) and the Committee's General Comment No. 5 on persons with disabilities apply to persons with mental illness; the Programme of Action of the International Conference on Population and Development held at Cairo in 1994, as well as the Declaration and Programme for Action of the Fourth World Conference on Women held in Beijing in 1995 contain definitions of reproductive health and women's health, respectively.

[4] Common article 3 of the Geneva Conventions for the protection of war victims (1949); Additional Protocol I (1977) relating to the Protection of Victims of International Armed Conflicts, art. 75 (2) (a); Additional Protocol II (1977) relating to the Protection of Victims of Non-International Armed Conflicts, art. 4 (a).

[5] See WHO Model List of Essential Drugs, revised December 1999, WHO Drug Information, vol. 13, No. 4, 1999.

[6] Unless expressly provided otherwise, any reference in this General Comment to health facilities, goods and services includes the underlying determinants of health outlined in paras. 11 and 12 (a) of this General Comment.

[7] See paras. 18 and 19 of this General Comment.

[8] See article 19.2 of the International Covenant on Civil and Political Rights. This General Comment gives particular emphasis to access to information because of the special importance of this issue in relation to health.

[9] In the literature and practice concerning the right to health, three levels of health care are frequently referred to: *primary health care* typically deals with common and relatively minor

illnesses and is provided by health professionals and/or generally trained doctors working within the community at relatively low cost; *secondary health care* is provided in centres, usually hospitals, and typically deals with relatively common minor or serious illnesses that cannot be managed at community level, using specialty-trained health professionals and doctors, special equipment and sometimes in-patient care at comparatively higher cost; *tertiary health care* is provided in relatively few centres, typically deals with small numbers of minor or serious illnesses requiring specialty-trained health professionals and doctors and special equipment, and is often relatively expensive. Since forms of primary, secondary and tertiary health care frequently overlap and often interact, the use of this typology does not always provide sufficient distinguishing criteria to be helpful for assessing which levels of health care States parties must provide, and is therefore of limited assistance in relation to the normative understanding of article 12.

[10] According to WHO, the stillbirth rate is no longer commonly used, infant and under-five mortality rates being measured instead.

[11] *Prenatal* denotes existing or occurring before birth; *perinatal* refers to the period shortly before and after birth (in medical statistics the period begins with the completion of 28 weeks of gestation and is variously defined as ending one to four weeks after birth); *neonatal*, by contrast, covers the period pertaining to the first four weeks after birth; while *post-natal* denotes occurrence after birth. In this General Comment, the more generic terms pre- and post-natal are exclusively employed.

[12] Reproductive health means that women and men have the freedom to decide if and when to reproduce and the right to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice as well as the right of access to appropriate health-care services that will, for example, enable women to go safely through pregnancy and childbirth.

[13] The Committee takes note, in this regard, of Principle 1 of the Stockholm Declaration of 1972 which states: "Man has the fundamental right to freedom, equality and adequate conditions of life, in an environment of a quality that permits a life of dignity and well-being", as well as of recent developments in international law, including General Assembly resolution 45/94 on the need to ensure a healthy environment for the well-being of individuals; Principle 1 of the Rio Declaration; and regional human rights instruments such as article 10 of the San Salvador Protocol to the American Convention on Human Rights.

[14] ILO Convention No. 155, art. 4.2.

[15] See para. 12 (b) and note 8 above.

[16] For the core obligations, see paras. 43 and 44 of the present General Comments.

[17] Article 24.1 of the Convention on the Rights of the Child.

[18] See World Health Assembly resolution WHA47.10, 1994, entitled "Maternal and child health and family planning: traditional practices harmful to the health of women and children".

[19] Recent emerging international norms relevant to indigenous peoples include the ILO Convention No. 169 concerning Indigenous and Tribal Peoples in Independent Countries (1989); articles 29 (c) and (d) and 30 of the Convention on the Rights of the Child (1989); article 8 (j) of the Convention on Biological Diversity (1992), recommending that States respect, preserve and maintain knowledge, innovation and practices of indigenous communities; Agenda 21 of the United Nations Conference on Environment and Development (1992), in particular chapter 26; and Part I, paragraph 20, of the Vienna Declaration and Programme of Action (1993), stating that States should take concerted positive steps to ensure respect for all human rights of indigenous people, on the basis of non-discrimination. See also the preamble and article 3 of the United Nations Framework Convention on Climate Change (1992); and article 10 (2) (e) of the United Nations Convention to Combat Desertification in Countries Experiencing Serious Drought and/or Desertification, Particularly in Africa (1994). During recent years an increasing number of States have changed their constitutions and introduced legislation recognizing specific rights of indigenous peoples.

[20] See General Comment No. 13, para. 43.

[21] See General Comment No. 3, para. 9; General Comment No. 13, para. 44.

[22] See General Comment No. 3, para. 9; General Comment No. 13, para. 45.

[23] According to General Comments Nos. 12 and 13, the obligation to fulfil incorporates an obligation to *facilitate* and an obligation to *provide*. In the present General Comment, the obligation to fulfil also incorporates an obligation to *promote* because of the critical importance of health promotion in the work of WHO and elsewhere.

[24] General Assembly resolution 46/119 (1991).

[25] Elements of such a policy are the identification, determination, authorization and control of dangerous materials, equipment, substances, agents and work processes; the provision of health information to workers and the provision, if needed, of adequate protective clothing and equipment; the enforcement of laws and regulations through adequate inspection; the requirement of notification of occupational accidents and diseases, the conduct of inquiries into serious accidents and diseases, and the production of annual statistics; the protection of workers and their representatives from disciplinary measures for actions properly taken by them in conformity with such a policy; and the provision of occupational health services with essentially preventive functions. See ILO Occupational Safety and Health Convention, 1981 (No. 155) and Occupational Health Services Convention, 1985 (No. 161).

[26] Article II, Alma-Ata Declaration, Report of the International Conference on Primary Health Care, Alma-Ata, 6-12 September 1978, in: World Health Organization, "Health for All" Series, No. 1, WHO, Geneva, 1978.

[27] See para. 45 of this General Comment.

[28] Report of the International Conference on Population and Development, Cairo, 5-13 September 1994 (United Nations publication, Sales No. E.95.XIII.18), chap. I, resolution 1, annex, chaps. VII and VIII.

[29] Covenant, art. 2.1.

[30] Regardless of whether groups as such can seek remedies as distinct holders of rights, States parties are bound by both the collective and individual dimensions of article 12. Collective rights are critical in the field of health; modern public health policy relies heavily on prevention and promotion which are approaches directed primarily to groups.

[31] See General Comment No. 2, para. 9.